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Ms. Bordeaux by Scan
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**Department
of Health**

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

September 16, 2025

CERTIFIED MAIL/RETURN RECEIPT

Timothy Osho, Esq.
NYS Office of the Medicaid Inspector General
90 Church Street
New York, New York 10007

Md Hasan

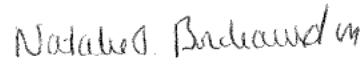

RE: In the Matter of Md Hasan

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter.

If the appellant did not win this hearing, the appellant may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the appellant wishes to appeal this decision, the appellant may wish to seek advice from the legal resources available (e.g. the appellant's attorney, the County Bar Association, Legal Aid, OEO groups, etc.). Such an appeal must be commenced within four (4) months after the determination to be reviewed becomes final and binding.

Sincerely,



Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB: cmg
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of

Md Hasan

from charges of unacceptable practices and a determination
to recover Medicaid Program overpayments.


Decision After
Hearing

#22-F-4985

Before: John Harris Terepka
Administrative Law Judge

Hearing date: August 27, 2025
By videoconference
Transcript received September 15, 2025

Parties: NYS Office of the Medicaid Inspector General
90 Church Street
New York, New York 10007
By: Timothy Osho, Esq.
Timothy.Osho@omig.ny.gov

Md Hasan


JURISDICTION

The Department of Health acts as the single state agency to supervise the administration of the Medicaid Program in New York. 42 USC 1396a; PHL 201(1)(v); SSL 363-a. The Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority to pursue administrative enforcement actions against any individual or entity that engages in fraud, abuse or unacceptable practices in the Medicaid Program, and to recover improperly expended Medicaid funds. PHL 30, 31 & 32.

The OMIG determined to exclude Md Hasan (the Appellant) from the Medicaid Program and to recover Medicaid Program overpayments. The Appellant requested a hearing pursuant to SSL 145-a and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the OMIG determination.

At this hearing, the OMIG presented the audit file and summarized the case, as is required by 18 NYCRR 519.17. The OMIG presented documents (Exhibits 1-11) and the testimony of Abdur Rahman, OMIG investigative specialist. The Appellant testified on his own behalf. A transcript of the hearing was made. (Transcript, pages 1-55.)

SUMMARY OF FACTS

1. During the period under review, Md Hasan was a non-enrolled provider in the New York State Medicaid Program, providing personal assistance services to his parent, [REDACTED], through the Consumer Directed Personal Assistance Program (CDPAP). Tradition Choice LLC (TCL) was his Medicaid enrolled fiscal intermediary. (Exhibits 4, 5; Transcript, pages 5-6.)

2. After receiving a referral resulting from an anonymous report, the OMIG investigated CDPAP claims submitted by TCL for the period November 2022 through March 2023 in which the Appellant was identified as the hired caregiver providing personal assistance services to his [REDACTED] (Transcript, pages 15-16.)

3. The OMIG issued a notice of proposed agency action dated October 17, 2024. The notice advised the Appellant that the OMIG proposed to exclude him from the Medicaid Program for three years and recover overpayments in the amount of \$8,541.45, plus interest, based upon his commission of unacceptable practices in the Medicaid Program. (Exhibit 1.) The Appellant responded to the notice of proposed agency action by letter dated November 1, 2024. (Exhibit 2.)

4. By notice of agency action dated April 9, 2025, the OMIG notified the Appellant that after reviewing his November 1, 2024 response, its determinations to exclude him from the Medicaid Program and recover Medicaid Program overpayments were unchanged. (Exhibit 3.) The Appellant requested this hearing by letter dated April 21, 2025. (Exhibit 11.)

5. The Appellant submitted timesheets to TCL reporting he provided daily care to [REDACTED] on 34 days from [REDACTED] to [REDACTED], 2022. (Exhibit 8.) The Appellant, but not [REDACTED], was traveling outside of the United States on those 34 days. (Transcript, pages 42-43, 47; Exhibits 2, 7.)

6. The Appellant submitted timesheets to TCL reporting he provided daily care to [REDACTED] on 35 days from [REDACTED] to [REDACTED] 2023. (Exhibit 9.) [REDACTED], but not the Appellant, was traveling outside of the United States on those days. (Transcript, page 48.)

7. TCL relied on the Appellant's signed timesheets to submit Medicaid Program claims for the reported care, and the Appellant was paid for services he did not provide.

ISSUES

Did Appellant Md Hasan engage in unacceptable practices in the Medicaid Program? If so, did the OMIG properly determine to exclude him from the Medicaid Program for three years?

Is the OMIG entitled to recover Medicaid Program overpayments in the amount of \$8,541.45 plus interest, from the Appellant?

APPLICABLE LAW

An unacceptable practice in the Medicaid Program is conduct contrary to the official rules, regulations, claiming instructions or procedures of the Department. 18 NYCRR 515.2(a)(1). Unacceptable practices include false claims, defined as submitting, or causing to be submitted, claims for unfurnished medical care; false statements, defined as making or causing to be made any false statement or misrepresentation of material fact in claiming a Medicaid payment, or for use in determining the right to payment; and failure to disclose, defined as having knowledge of any event affecting the right to payment of any person and concealing or failing to disclose the event with the intention that a payment be made when not authorized. 18 NYCRR 515.2(b)(1),(2)&(3).

Upon a determination that a person has engaged in an unacceptable practice, the Department may impose one or more sanctions, including exclusion from the Medicaid Program for a reasonable time, and may require the repayment of overpayments determined to have been made as a result of an unacceptable practice. 18 NYCRR 515.3(a)&(b), 515.9, 518.1(c). The Department may require repayment from the person

submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim. 18 NYCRR 518.3.

A person is entitled to a hearing to have the Department's determination reviewed if the Department imposes a sanction or requires repayment of an overpayment. 18 NYCRR 519.4. At the hearing, the Appellant has the burden of showing that the determination of the Department was incorrect and of proving any mitigating factors affecting the severity of any sanction imposed. 18 NYCRR 519.18(d).

DISCUSSION

The Consumer Directed Personal Assistance Program (CDPAP) is intended to permit individuals in need of home care services greater flexibility and freedom of choice in obtaining such assistance under the Medicaid Program. Unlike a personal care aide (PCA), a CDPAP personal assistant (PA) can be a family member of the individual receiving care. 18 NYCRR 505.28. Wage and benefit processing for the PA is handled by a Medicaid enrolled fiscal intermediary, which maintains records including documentation of the time spent in provision of services. 18 NYCRR 505.28(j).

The Appellant was approved to provide seven days totaling 41 hours per week of Medicaid covered CDPAP services to his [REDACTED]. He submitted timesheets for his hourly services to TCL, which processed the claims, submitted them to the Medicaid Program, and paid the Appellant. The OMIG determination is based upon its findings that the Appellant submitted timesheets to TCL indicating he provided CDPAP services to [REDACTED] in [REDACTED] and [REDACTED] 2022, when he was overseas, and in [REDACTED] and [REDACTED] 2023, when [REDACTED] was overseas.

The Appellant acknowledges that either he or [REDACTED] was out of the country for the 69 days he reported providing services and for which he was paid. He claims he informed TCL about this and did not know he was doing anything wrong. (Exhibit 2.) His claim is inconsistent with his submission of twelve weekly timesheets reporting specific hours of personal care to [REDACTED], with the representation:

By signing and submitting my timesheets, I acknowledge that all services ere [sic] satisfactorily performed on each days [sic] as indicated on the timesheet. (Exhibits 8, 9.)

At the hearing the Appellant claimed he did not submit the false timesheets while he was overseas but instead was advised by TCL to come in to sign them when he returned. (Transcript, page 43.) These weekly timesheets he claimed at the hearing to have signed all at the same time are, like the timesheets he submitted in 2023 when it was [REDACTED] who was overseas, each signed and dated at the end of the week in which the services were allegedly provided. The timesheets themselves state: "timesheets are due each Monday... I understand any unsigned timesheet will not be processed for payment." (Exhibits 8, 9.) His testimony also contradicted his response to the notice of proposed agency action, in which he stated:

I informed TCL of my travel plans via phone. I was advised to continue submitting timesheets, which I did. (Exhibit 2.)

False timesheets are false timesheets whenever they are signed. The Appellant's claim that he did not read the timesheets and simply followed TCL advice does not justify or excuse his signing, dating and submitting detailed handwritten false information on those timesheets.

Medicaid Program Overpayments

These 69 claims for daily services were submitted by TCL under its Medicaid provider number for services provided by the Appellant, and the Medicaid payments that the OMIG seeks to recover, in the amount of \$8,541.45, were received by him. (Exhibit 6; Transcript, pages 32-34.) The Department's records of the nature and amount of payments made under the Medicaid Program are entitled to a presumption of accuracy that was not challenged by the Appellant or called into question by any evidence.

The Appellant acknowledges he received payments for services on dates he or [REDACTED] were separately out of the country. (Exhibit 2; Transcript, pages 42-43, 47-49.) The claims are not authorized to be paid under the Medicaid Program because the Appellant submitted false records of services that he did not provide. He can hardly expect to be paid for services he did not provide and does accept responsibility for repayment. (Transcript, pages 44-45.) The OMIG is entitled to recover the overpayments from him. 18 NYCRR 518.3(a).

Medicaid Program exclusion

Upon a determination that a person has engaged in an unacceptable practice, the Department may impose sanctions, including censure or exclusion from the Medicaid Program for a reasonable time. 18 NYCRR 515.3(a), 515.4(a). Exclusion means that items of medical care, services or supplies furnished by the provider will not be reimbursed under the Medicaid Program. 18 NYCRR 515.1(b)(6). The OMIG proposes a three-year exclusion.

Pursuant to 18 NYCRR 515.4(b), in determining the sanction to be imposed the following factors will be considered:

- (1) the number and nature of the program violations or other related offenses;
- (2) the nature and extent of any adverse impact the violations have had on recipients;
- (3) the amount of damages to the program;
- (4) mitigating circumstances;
- (5) other facts related to the nature and seriousness of the violations; and
- (6) the previous record of the person under the Medicare, Medicaid and social services programs.

The nature of the program violations in this case goes to the essence of the OMIG's ability to oversee the Medicaid Program. Over eight thousand dollars in Medicaid reimbursement for 69 days of care was paid by the Medicaid Program as the result of the Appellant's repeated submission of time sheets making false representations that he provided the care. The care was not inadequately or incompletely provided; it was not provided at all. The Appellant offered no explanation whether or how [REDACTED] received the services for which he had been approved as a matter of medical need during those months. The Appellant engaged in this conduct in [REDACTED] and [REDACTED] 2022, and then did it again in [REDACTED] and [REDACTED] 2023.

The Appellant has the burden of proving any mitigating factors affecting the severity of any sanction imposed. 18 NYCRR 519.18(d)(2). The Appellant pleads that he is the appropriate caregiver for his [REDACTED] claims that he was unaware that he was in violation of billing rules, and says that he is willing to make restitution for his mistake. He has no previous record of violations in the Medicaid Program.

The Appellant offered only a vague and bare claim that TCL advised him it was acceptable to falsify his time sheets. It is difficult to credit his claim that he made an honest mistake and somehow did not know he was claiming payment for care he simply did not provide. He claimed he did not submit timesheets when he or the patient were out of the country (Transcript, pages 46, 48), but then acknowledged that he later filled in by


hand, signed and submitted timesheets to TCL covering the pay periods in question. (Transcript, pages 42-43.) These time sheets explicitly stated in his handwriting that he provided six hours daily care and five hours on Saturday. Above his signature was an express representation, by him, that the services were provided when in fact they were not. (Exhibit 8, pages 55-60; Exhibit 9, pages 67-72.) It was not reasonable or understandable for him to rely on what appears to have been an assumption on his part that he could get away with fraud.

DECISION: The OMIG's determination to exclude Appellant Md Hasan from the Medicaid Program for a period of three years is affirmed.

The OMIG's determination to recover Medicaid Program overpayments in the amount of \$8,541.45 plus interest from Appellant Md Hasan is affirmed.

This decision is made by John Harris Terepka, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Rochester, New York
September 16, 2025



John Harris Terepka
Bureau of Adjudication